FACT CHECKER REPORT #1 AND REWRITE

December TK, 2021

The Reader published Len Goodman's column of November 24, 2021, in violation of its ordinary standards for accuracy. The piece should not have run in its original form. Goodman is co-owner of the for-profit arm of the Reader, and given the sensitivity of his subject matter, even the potential for the appearance of undue influence on his part should have been enough to push us to delay the column and complete the thorough fact-check to which it has now been subjected.

The results of that fact-check are below. The column has been extensively modified; additions are in bold, and original text that has been deleted is indicated with a strike-through. Some of the additions are not fact-checks but rather attempts to stitch together the gaps left by deletions of inaccurate material, so that the column would not be reduced to a string of disconnected fragments. Many points that arose during the fact-check could not be addressed in the modified text of the column; those points are explained in the following list.

1. Len Goodman wrote that Pfizer and other vaccine manufacturers don't advertise their vaccines by name because the omission allows them to sidestep FDA regulations about listing risks and side effects. This is untrue. Vaccine manufacturers have not advertised their vaccines at all, at least not directly. (Goodman's column suggests that some media stories have been tantamount to ads.) Advertising requires full FDA approval, not just an emergency use authorization (EUA). If Pfizer begins to advertise its vaccine, which received FDA approval earlier this year, it will have to follow regulations and list side effects. This piece of misinformation may have originated in an Instagram post, most variants of which have since been flagged or deleted.
2. Goodman wrote that "no actual data from the vaccine trials has been provided to the public." This is misleading. Aggregated data submitted by vaccine manufacturers for all phase III trials of Pfizer, Moderna, and Johnson & Johnson vaccines are available online, and the FDA includes detailed analyses of its review of this data in its decisions to authorize those vaccines. It is true that the totality of raw data underpinning the trials is not available, in part because it contains patient information and trade secrets. However, that kind of raw data is not typically made available during the FDA approval process, so this is not unusual.
3. Goodman characterized a report in the British Medical Journal as claiming that a research company involved in the Pfizer phase III trial had falsified data and unblinded patients, among other issues. The report doesn't provide any evidence of there having been falsified data, and states only that patients may have been unblinded.
4. Goodman referred to a report from Sweden that found a low incidence of COVID in schoolchildren and teachers, using it to make the case that kids are at low risk to spread COVID. This is misleading. The report is from the first three months of the pandemic, when Sweden's rate of cases was less than the current U.S. rate. The report also precedes the emergence of deadlier and more transmissible variants, and didn't track household transmission.
5. Goodman quoted Dr. Robert Malone claiming that higher vaccination rates lead to a

greater number of vaccine-resistant strains of the virus. There is no evidence that this is the case. Variants are more likely to emerge in low-vaccinated populations, because those conditions make it easier for the virus to infect, replicate, and mutate. According to some researchers, the risk of specific vaccine-resistant mutation is not only very low but outweighed by the proven benefits of vaccination.

6. Goodman quoted Mexico's health minister, Jorge Alcocer Varela, suggesting that COVID vaccines inhibit the development of children's immune systems and that vaccines in general prevent children's immune systems from learning how to function properly. There is no evidence that this is the case with COVID vaccines or any other vaccines. Childhood vaccines have saved tens of millions of lives over the past century and helped eradicate diseases such as smallpox and polio.

7. Goodman referred to a study that compared different countries and U.S. counties and claimed to find a correlation between high vaccination rates and higher spread of COVID. The study has many serious methodological flaws. It does not take into account relevant differences between the areas compared, such as prevalence of mask wearing, social distancing, and lockdown policies. It also does not evaluate the completeness of the data, which it needed to do because some areas have better reporting systems than others. A preponderance of the evidence suggests that vaccines limit infection and spread.

8. Goodman wrote that ivermectin is a safe and effective treatment for COVID and has been used as such by countries around the world. Ivermectin has not been found to be a safe and effective treatment of COVID. It has at times been recommended by governments when they did not have access to vaccines and were trying anything available during spikes in cases; some individual patients have used it for the same reasons, and others continue to use it now, for reasons beyond the scope of the present writing. Relatively small analyses that claim ivermectin is effective have been found to contain methodological flaws, and large-scale studies are underway in hopes of settling the question.

9. Goodman suggested that the mainstream media have disparaged ivermectin in part to leave the field clear for vaccines to receive emergency use authorizations (EUAs). EUAs are only granted in the absence of effective pre-existing treatments for a disease, so the thinking goes that if ivermectin, a pre-existing drug, were recognized as effectively treating COVID, then no EUAs could happen. This is wrong for several reasons. Ivermectin is an approved drug, but it is not an approved COVID treatment. If it were approved to treat COVID, it would likely be through an EUA, given how long the FDA's full approval process takes. And in no case would the approval of ivermectin interfere with the approval of vaccines, because the former is an (alleged) treatment and the latter are preventative measures. Eleven different treatments currently exist with EUA status for COVID, none of which has prevented the vaccines from receiving EUAs.

REWRITE OF COLUMN

As a father of a young child, I am pressured to get my daughter vaccinated for COVID-19. And like many Americans, I have concerns about giving my six-year-old a new vaccine that was not tested on humans until last year, and that has been approved only for "emergency use" in kids. The feverish hype by government officials, mainstream media outlets, and Big Pharma, and the systematic demonization and censorship of public figures who raise questions about the

campaign, provide further cause for concern.

This year, Pfizer has banked on selling 115 million pediatric doses to the U.S. government and expects to earn $36 billion in vaccine revenue. Congress is so in the pocket of Big Pharma that it's against the law for our government to negotiate bulk pricing for drugs, meaning taxpayers must pay retail. Corporate news and entertainment programs are routinely sponsored by Pfizer, which spent $55 million on social media advertising in 2020. Even late night comedians like Jimmy Kimmel, who has called for denying ICU beds to unvaccinated people, have been paid by pharmaceutical companies Big Pharma to promote the COVID-19 vaccine.

It is not helpful that many of the stories reported in the press about vaccine safety and efficacy quote from vaccine manufacturers' press releases without analyzing the data themselves or bringing on experts to do so. It is thus not surprising that most of the information reported in the press about vaccine safety and efficacy appears to come directly from Pfizer press releases. This recent headline from NBC News is typical: "Pfizer says its Covid vaccine is safe and effective for children ages 5 to 11." And while analyses of the data are accessible and media stories tend to point out that whether the vaccines actually become available is contingent on FDA authorization, I expect journalists to be more critical of what is essentially a sales pitch.

Moreover, by not advertising their vaccines by name, Pfizer-BioNTech and other drugmakers are not obliged, under current FDA regulations, to list the risks and side effects of the vaccine.

Most Americans are vaguely aware that COVID vaccines carry some potential risks, such as heart inflammation, known as myocarditis, seen most often in young males. But while studies from all authorized vaccine phase III trials are publicly available and the FDA has published its justification for each authorization, I'm worried we're not getting the full picture. A group of scientists—which admittedly includes some who are anti-vaccine—sent the FDA a FOIA request for all the data it relied on to authorize the Pfizer COVID-19 vaccine, which amounted to some 400,000 pages. In November 2021 the FDA proposed to send just 500 pages per month, citing the need to redact the data to protect patient information and trade secrets as well as the limitations of its FOIA department—at the time, it had just ten officers, who were working through hundreds of other requests. At that rate, the full data set wouldn't be available until 2075.

Even though the FDA doesn't usually provide the public with all the raw data from its drug-approval process, I'd argue that given our public health emergency, it would build public confidence if the agency hired a few more FOIA officers to expedite the process. But no actual data from the vaccine trials has been provided to the public. After promising "full transparency" with regard to COVID-19 vaccines, the FDA recently went to court to resist a FOIA request seeking the data it relied on to license the Pfizer COVID-19 vaccine, declaring that it would not release the data in full until the year 2076—not exactly a confidence-building measure.

Also troubling is a recent report in the British Medical Journal, a peer-reviewed medical publication, which found that the research company used by Pfizer employed inadequately trained vaccinators, may have falsified data, unblinded patients, and was slow to follow up on adverse events reported in Pfizer's pivotal phase III trial. The whistleblower, Brook Jackson, repeatedly notified her bosses of these problems, then e-mailed a complaint to the FDA and was fired that same day. Granted, the company accounted for just 1,200 participants out of 44,000 in the phase III trial, and three sites out of 123. A clinical trials expert explained that potential issues in such a small fraction of the data don't undermine the trial, and the FDA does do random inspections of trial sites for quality control. But the report makes me wonder if there are more quality-control issues in the trials than we, the FDA, or even Pfizer knows about. If this scandal

was ever mentioned in the corporate press, it was with a headline like this from CBS News: “Report questioning Pfizer trial shouldn’t undermine confidence in vaccines.”

The On the other hand, the initial rollout of the vaccine appeared to be a home run. Reported numbers of new infections went down, and oppressive lockdown rules were lifted. Our bars, restaurants, and gyms opened up. Plus, my own experience getting the vaccine was positive, as I wrote about in an earlier column for the Reader. Is it possible that this time, the corporate media and government got it right? Is the mass vaccination of everyone, including kids, really the solution to our long COVID nightmare? I have tried my best to look objectively at the available evidence in order to make the best decision for my daughter. In this column, I share my findings.

One argument for vaccinating kids is to protect others, such as family members and schoolteachers. However, while most adults perceive children as little germ factories, the data on just how well kids spread COVID is mixed: some studies suggest kids spread COVID as easily as adults, whereas others suggest they spread it less. The CDC has found correlations between transmission rates in schools and transmission rates in the community. The argument made most often is that we must vaccinate our kids to protect others. However, while most adults perceive children as little germ factories, the data suggests that kids are at low risk to spread COVID. Reports from Sweden, where schools and preschools were kept open, and kids and teachers went unmasked without social distancing, show a very low incidence of severe COVID-19 among schoolchildren or their teachers during the SARS-CoV-2 pandemic.

Kids in the 5-11 age range are among the lowest risk groups for developing severe symptoms, requiring hospitalization, or dying from COVID-19. Of course, some risk is still risk; out of two million cases in that age range, more than 8,000 kids have been hospitalized and 200 have died, disproportionately Black, Latinx, and Indigenous. Still, I wonder if it's possible that the potential dangers of vaccinating outweigh these known dangers. Or as the New York Times’s David Leonhardt recently put it, unless your child has preexisting conditions or a compromised immune system, the danger of severe COVID is “so low as to be difficult to quantify.” This raises the question: If the risk for kids is so low, what is the emergency that justifies mass vaccination of children without waiting for proper testing trials of the vaccine?

I was surprised to learn that one of the first scientists to do groundbreaking work on mRNA technology—used decades later in some COVID vaccines—opposes mass vaccination. Dr. Robert Malone explains that I was also surprised to learn that there are reputable scientists opposed to mass vaccination, such as Dr. Robert Malone, an original inventor of the mRNA vaccine technology behind the COVID vaccines. As Malone explains, the mRNA vaccine contains a spike protein, similar to the virus, that stimulates your immune system to produce antibodies to fight COVID. He describes the vaccine as "leaky" because it is not 100 percent effective in preventing infection and spread. Various studies report that being fully vaccinated reduces infection and spread by between 50 and 90 percent, but the effectiveness of the first vaccine formulations goes down with newer variants such as Delta. He describes the vaccine as “leaky,” meaning it is only about 50 percent effective in preventing infection and spread.

Malone believes that mass vaccination during a pandemic makes it more likely for vaccine-resistant mutations to develop, leading to a "vaccine ‘arms race’ . . . for ever more potent boosters." Malone warns that overuse of a leaky vaccine during an outbreak risks generating mutant viruses that will overwhelm the vaccine, making it less effective for those who really need it. “The more people you vaccinate, the more vaccine-resistant mutations you get, and in the vaccine ‘arms race,’ the more need for ever more potent boosters.” Thus, Malone recommends

vaccinating only the most vulnerable—primarily the elderly and individuals with significant comorbidities such as lung and heart disease or diabetes—and not healthy children. Others have challenged this view for lacking evidence and countered that observed mutations are more likely to occur in low-vaccinated populations, where the virus has greater freedom to spread and reproduce. They argue that the benefits of vaccination outweigh the potential risks of vaccine-resistant mutation. But with Omicron on the way, the best method to prevent the emergence of new variants is worth thinking about.

If these views sound unfamiliar, it's likely because Malone and other critics of mass vaccination have faced heavy suppression on social media and vicious attacks from corporate media outlets. Meanwhile the U.S. mainstream press has ignored recent statements by Mexico's health minister, Jorge Alcocer Varela, who recommends against vaccinating children, warning that COVID-19 vaccines could inhibit the development of children's immune systems. "Children have a wonderful immune system compared to the later phases . . . of their life," he explained, warning that "hindering" the "learning" of a child's immune system—the "cells that defend us our whole lives"—with a "completely inorganic structure" such as a vaccine runs counter to public health.

A recent Harvard study provides further evidence that while vaccines protect us against serious COVID illness and deaths, they alone are not very good at stopping the spread of the disease. The study looked at COVID numbers in 68 countries and 2,947 counties in the United States during late August and early September. It found that the countries and counties with the highest vaccination rates had higher rates of new COVID-19 cases per one million people. And suggested other measures, like mask wearing and social distancing, in addition to vaccination.

In place of mass vaccination, Malone recommends early intervention with therapeutics such as shown to be effective against COVID, including ivermectin. In contrast, the corporate press has shamelessly attacked early treatments, and especially ivermectin, which it calls a veterinary drug, in reference to the fact that it is used to treat both animals and humans, along with many other drugs, including antibiotics and pain pills). Ivermectin was developed as an antiparasitic medication for diseases such as river blindness, scabies, and head lice. It has been safely used by billions of people around the world for those purposes.

At the start of the pandemic, an in vitro study found ivermectin effective in stopping the replication of the coronavirus. Unfortunately, the quantities used in the study would be unsafe if consumed by people.

Since then, some people have taken ivermectin in safe and approved dosages to treat COVID. Some governments, including in Mexico and Peru, even handed out ivermectin as part of COVID kits during spikes in cases, though they've stopped recommending it as vaccines have become more widely available.

Some studies claim to show that areas where ivermectin was distributed had decreased COVID mortality. Others have critiqued these studies for methodological flaws, including not establishing that ivermectin was the cause (the kits often contained other drugs, and the studies didn't track whether people actually took ivermectin). Currently, the CDC has not seen enough evidence to prove ivermectin effective in treating COVID, but there's enough promise that large-scale studies are underway.

Meanwhile, some mainstream media outlets have attacked ivermectin without delving into the data, calling it a veterinary drug, in reference to the fact that it is used to treat both animals and humans. But that's also the case for many other drugs, such as antibiotics and pain pills.

In October, popular podcaster Joe Rogan announced on his program that he had contracted the

virus and took ivermectin, prescribed by a doctor, along with other therapeutics including monoclonal antibodies, and that he only had “one bad day” with the virus. CNN ridiculed Rogan for taking “horse dewormer.” On his show, Rogan grilled CNN medical expert Sanjay Gupta. “Why would they lie [at your network] and say that’s horse dewormer? I can afford people medicine.” Rogan pointed out that the developers of ivermectin won the Nobel Prize in 2015 for the drug’s use in human beings (though that was strictly for its effectiveness against parasitic diseases, not viral ones).

It's one thing to note that more studies are needed to establish whether ivermectin is effective, and another to make fun of it by calling it horse dewormer. I wonder if ivermectin being off-patent has anything to do with that. Any company can make it, which could keep prices down. Meanwhile, Pfizer's antiviral drug in development, PF-07321332, will be priced at more than $500 per course. I know I'll be looking forward to seeing what those ivermectin studies find.

Why indeed is CNN and much of the mainstream press lying about ivermectin, a drug that has been used by literally billions of people to treat tropical diseases, and has been shown to be safe and effective in treating COVID in countries such as Mexico, India, Japan, and Peru? First, in order for there to be an emergency use authorization for the vaccines, there has to be no treatment for a disease. Thus, any potential treatments must be disparaged. That is, of course, until Pfizer releases its antiviral drug, PF-07321332.

Second, ivermectin is off patent, meaning Big Pharma can’t make a profit on it. It has been made available to poor people around the world at pennies a dose. In contrast, Pfizer’s COVID pill will be priced at more than $500 per course.

At this point, you can guess the end of the story. The final straw for me is the apparent lack of durability of the COVID vaccines. Recent data indicates that after six months, the effectiveness of vaccines in preventing infection goes down from 90 percent to 80 percent or 70 percent. the limited protection from the vaccine lasts only four to six months. Since COVID is not going away, is it Pfizer’s plan to artificially boost my daughter’s immune system every four to six months for the rest of her life?

It’s not especially clear yet whether kids are as likely to spread COVID as adults. Leaving aside the potential worry that widespread vaccination could encourage vaccine-resistant mutations, as well as the possibility that affordable, effective COVID treatments may soon be available, one big issue remains: vaccine makers have a financial incentive to persuade us their products are safe and effective, and thus a serious conflict of interest. We have been kept in the dark about vaccine safety and efficacy by our government and its partners in Big Pharma, who tell us they have looked at the science and it supports vaccinating our children against a virus that presents them with only the most miniscule risk of serious illness. As a parent, I will demand more answers before simply taking their word.